

Managed Competition: The Solution For Health Care Reform

An Honors Thesis (HONRS 499)

by

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Purpose of Thesis

Receiving health care is becoming increasingly costly while at the same time those who need the care most are not getting it. As a society, Americans spent over \$666 billion on health care in 1990, or 12.2% of GNP. This is compare to 7% in 1970 and 9% in 1980. Skyrocketing costs combined with the fact that over 37 million Americans are without health insurance has fired the debate for health care reform. The question that now needs to be answered is not whether we should reform the system, but in what form should reform take place. The objective of this paper is to analyze several proposals of providing health care to the United States. Managed competition will then be discussed thoroughly as the greatest possibility for success in health care reform.

Present Status of the Health Care System

The 1992 presidential election brought to surface many topics the American people want changed. One of those major topics that needs to be reformed is health care. Last year's election is the first since the 1972 Nixon election to discuss the need for reform in health care industry. To receive health care is becoming increasingly costly to while at the same time those who need the care most are not getting it. As a society, Americans spent over \$666 billion on health care in 1990, or 12.2% of GNP. This is compared to 7% in 1970 and 9% in 1980. Meanwhile, 37 million Americans are without health insurance because they are either too young for medicare or they are ineligible for public programs for the poor. It is plain to see that our costs are skyrocketing and if something is not done to contain costs, 20% of our nations GNP could be used for health care by the year 2000 (Sullivan 801). The American system of health care financing and delivery is deteriorating. The causes of the problem are complex, and reform must emphasize the most important and correctable aspects.

Among the major reasons for rising health care costs is that the system provides more incentives to spend than to avoid spending. The fee-for-service system pays more for doing more, with no budget for how much a job should cost, and there is no price competition. Health Maintenance Organizations (HMO) are more cost effective because they make doctors compete for their business, but often employers do not offer the alternative.

A second problem is that the present system encourages specialists to exercise their specialties, not to produce acceptable outcomes at a reasonable cost. The current system pays more to incompetent and inefficient physicians who have high rates of complications (therefore more procedures, tests and hospital days for patients), while high-quality physicians are unrecognized and unrewarded. There are too many hospital beds and too many specialists compared with primary care physicians.

Third, insurance companies are not designed to efficiently purge waste in the health care industry.

In the past, payers never paid much attention to provider charges. Insurance companies simply paid the claims (Wooley 22). The past has now created a system designed to exclude those who need the care most. Mr. Maturi of the BC/RC Association believes: "Insurers are paying more attention to making sure they aren't cherry-picked instead of developing competitive products" (Qtd. in Wooley 22).

Fourth, there is an oversupply of high-tech medical equipment in the U.S, from cardiac intensive care units to magnetic resonance imaging machines. The fact that this oversupply has never been addressed on a national level makes it almost inevitable that there will be waste in the system.

Finally, public funds are not distributed equitably or effectively as evidenced by the problems with under-funding in medicare and medicaid (Enthoven, Kronick 532-7).

Skyrocketing costs combined with the fact that over 37 million Americans are without health insurance has led this debate for reform. The question that now needs to be answered is not

whether we should reform the system, but how should we reform the system. The objective of this paper is to analyze several proposals of providing health care to the United States. Managed competition will then be discussed thoroughly as the greatest possibility for success in health care reform.

Proposals for Change

President Clinton's Proposal for change

President Bill Clinton's Health Care reform plan for the 1992 election campaign indicated he will streamline the insurance system, guarantee benefits, limit cost increases, reduce bureaucracy, reduce increases in drug prices, reduce billing fraud and more. However, his plan for health care reform is very vague and incomplete because he does not really make clear how he is to do this.

He proposes to build on America's public-private partnership in health care. Employees and employers would either purchase private health care benefits or participate in public programs that offered a core benefit package to be established by a National Health Board. Americans not covered through an employer would participate in the public programs. The phrasing of this passage in Clinton's plan is not clear. There are words in his statement to please supporters on both sides.

One side can interpret the passage as endorsing a so called "play or pay" plan that would require employers outright to pay a

(flat payroll tax of 7% into what he calls a "federal government-run health insurance program for those not covered by private insurance." Such a plan would effectively make business community the chief tax collector for the insurance system. Business in turn would pass this cost on-either forward to consumers in the form of higher prices or, more likely, backward to employees in the form of lower salaries or reductions in other fringe benefits (Reinhart 810-1).

The other side of the coin sees Clinton's phrasing as compatible with parts of the Jackson Hole Initiative. The Initiative is a plan in which business would not be required either to offer employees health care insurance or to collect a payroll tax. Instead, the plan would allow Americans' who did not choose to be insured by an employer to be folded into a fail-safe system for which they would be charged a progressive federal income tax. Under this scheme, the federal government would take the responsibility of collecting the funds for health insurance. The providers would be paid by the competing privately managed care system. Under the system, the president's plan would rely on "managed competition" coupled with both managed care and fee-for-service practices as the chief workhorse of cost containment (Reinhart 811).

(President Clinton would subject his collaborative health networks to global budget targets established at both the national and state levels by a National Health Board. This board, which would also specify a basic benefit package for all Americans, would be composed of representatives of all major stakeholders in health

care. So far, the president's plan has not explained how the proposed global budgets would be transmitted to the individual providers of health care. Alain C. Enthoven, co-author of the Jackson Hole Initiative, believes that it does not matter how the global budget works because "price control simply do not work, especially in a field as complex and dynamic as health care" (Enthoven 809). He goes on to say that government is too distant to have a control relationship over doctors. "This scheme would lock in the fee-for-service, remote-third-party payment model that is at the root of so many of our present problems" (809).

The government would then suffer because people that would choose the plan would mostly be the lowest paid and the sickest. In turn, revenues would fall short and costs would run over global budgets. The government would have to raise taxes which would in turn cause the "healthy" people to drop out of the public plan. The uproar caused by the higher taxes would put pressure (from smaller businesses) on the government to abandon the system causing an addition to the federal deficit. If this scenario were to happen, the occurrence would be a familiar site. How many times has the American tax payer had to bailout a federal institution in recent years? A few good examples are the S&L crisis, the FDIC's bailout and the Medicare Hospital Insurance problem.

President Clinton has several good ideas in his plan. The best ideas of his plan are the parts that resemble "managed competition" which is outlined in the Jackson Hole Initiative. The worst ideas of his plan are the parts of his plan that resemble a "play or pay" scheme of things which would cause an even greater bureaucracy. If

the president leans toward this side of the proposal in which he goes to global budgets, the scenario proposed above probably could happen. If Clinton proposes more of a competitive market such as "managed care", then the system could be purged of the waste that needs to be eliminated. At the end of his campaign, then Governor Clinton was moving in the direction of managed competition. I believe this would be the favorable direction to go for health care reform.

Definition of Managed Competition

Managed competition was termed 25 years ago by the Jackson Hole Initiative. The Initiative was created by a group of self-selected health care executives, scholars and physicians that meet each year in Jackson Hole, Wyoming. This group, led by Dr. Paul Ellwood of Minnesota and Professor Alain Enthoven of Stanford University, formulated the shrewd plan that is known as managed competition today. Under this plan, individuals would be organized into large groups and represented by sophisticated buyers called sponsors. The sponsor would solicit bids from competing insurance companies and health care providers. The idea is to control costs through tightly managed competition rather than price controls, thereby preserving the crowning glory of U.S. Health Care: its endless capacity for innovation.

The sponsors would standardize the contracts that insurers offer. Members could choose simply and wisely on the basis of lowest price. Sponsors would monitor treatment outcomes and prevent discrimination against the chronically ill. Under the

plan, sponsors would be able to improve care in ways individuals could not do on their own. They would, for example, concentrate specific procedures, like heart by-pass surgery in a particular regional hospital. Concentration of specific procedures is the best way studies have shown to cut down mishaps (Weinstein 14).

The large buying pools would be categorized into two segments. One segment would consist of employer based pools which would provide health care for their employers and their families. The second segment would consist of the part of the country that does not have an employer such as small business, the unemployed and the poor. The second category is known as Health Insurance Purchasing Cooperatives (HIPC's). HIPC's allow small businesses to dictate rates that they could never get on their own. HIPC's also bring in the poor, unemployed and elderly, which would use Medicare and Medicaid as the financial backing for the pools. The system would encourage the growth of efficient Health Maintenance Organizations (HMO's).

HMO's offer coverage by a fixed panel of doctors for prepaid premiums. That system creates a powerful incentive to keep customers healthy and avoid wasteful treatment if given the proper incentives. The main problem is that in the past, the HMO have not been run efficiently because they were not made to compete on price. The typical pattern was an employer had an open-ended poorly controlled inflationary fee-for-service plan. For the HMO's to work as a curb, managed competition needs to use the defined contribution plan. In the defined contribution approach, employers contributions are pegged to the lowest price plan. Employees that

choose the plan that costs more than the lower priced plan must pay more. Therefore, they have an incentive to make an economic choice.

For managed competition to work properly, two changes would be needed in the Federal Tax laws. First, there needs to be a limit on how much premiums employers are allowed to provide tax-free. Currently, employer-paid premiums are fully deductible, no matter how wasteful. By imposing a tax cap, employers and employees would be encouraged to choose low-cost managed care plans. Second, managed competition plans would deny tax deductibility to smaller employers that refuse to join large groups to buy medical insurance. Small employers deciding to go it alone, as of right now, pay premiums according to their claims, compelling them to discriminate against job applicants who seem likely to become chronically ill (Weinstein 14).

Proposals for Managed Competition

The Xerox Experience

One example that proves managed competition can work is with the Xerox corporation. Before last year, Xerox's employees were able to pick expensive and inefficiently run health insurance plans whose premiums were increasing by 20% a year. Since last year, Xerox began pegging its contributions to the cost of the most efficient health maintenance organizations. If you wished to purchase health coverage that was more expensive than your local

"benchmark" plan, you would pay the substantial difference. The result has been that many of the employees have switched to the benchmark HMO's, whose average premium rose only 7.7% in 1992 and next year are expected to climb by 5.5%. This example proves that with the proper incentives, market forces alone can contain medical cost outlays just as they influence what is spent on food and housing. Although Xerox offers great evidence that managed competition can work, it is not the only one (Faltenmayer 84).

Minnesota's Experience

In 1989, Minnesota's state government became the first big employer to base its health care contributions for 120,000 employees and dependents on the lowest priced HMO in each county. The state employees were quite price-sensitive and moved toward the lowest cost plans. This year Minnesota's plans finally paid off with premium increases reaching the single digits. Next year, the premium of the lowest priced HMO, Group Health of Minnesota, will rise only 5.5% (Faltenmayer 84).

The major criticism of HMO's in Minnesota is they do virtually all of their business with large employers such as the state government. As a result, the HMO's have been no more successful at expanding health care coverage to the 300,000 people in the state who are underinsured than commercial insurance companies have. They have also shown little interest in signing up consumers who are not part of an employer group, especially people who may be sick. This is where another major point of managed competition

comes into play. Health Insurance Purchasing Cooperatives (HIPC's), which have begun in Minnesota, use their sophisticated knowledge and buying clout to provide HMO coverage at the best possible rates on behalf of a group of smaller employees (87).

What is to be learned from Calpers

HIPC's sound great theoretically but the question is will they work in a real life situation. The answer can be seen through the results of the California Public Employees Retirement System (Calpers). Calpers, which negotiates prices primarily on behalf of active employees of state and local government entities, already operates a prototypical HIPC. Calpers lines up health coverage for 874,000 workers, retirees, and dependents at 784 employers, including some as small as two workers. Calpers' huge buying pool allows these small employers to try insurance at rates that they could never get on their own. Tom Elkin, the Calpers assistant executive officer in charge of health benefits programs comments: "We aggressively negotiate premiums, taking advantage of our \$1.3 billion dollar lever" (Faltenmayer 88). The pressure has worked. In early 1992, with the recession still squeezing state and local governments. Calpers sought a zero increase in rates and was able to hold all but two health plans to an average increase of 3.1% for the 12 months beginning in August. That saved the system 90 million. The two programs which refused to budge from their proposed increases were disciplined with a one-year freeze on new enrollments. "The freeze captured their attention," says Elkin,

who reports he's optimistic that they will be more amenable in 1993 negotiations (88).

Universal Coverage Proposals

Hawaii's Experience

Hawaii spent 8% of its gross state product on health services compared to the United States' average of 11% of GNP in 1988. Dr. John Lewin, director of Hawaii's state health department says, "Hawaii's good fortune is directly result of near-universal health insurance coverage and the state's emphasis on primary and preventive care" (Consumer Reports 589). The main part of the Hawaiian health care system, The Prepaid Health Care Act, requires employers to provide health-insurance coverage for their full-time workers. These employers do not have to cover employees' families, but most employers do since unemployment is low and businesses must compete for workers. This act requires insurers to accept all employees, even those with health problems. Because everyone is covered, each insurer's "risk pools" automatically include both the sick and well. Insurers do not have to pad their premiums to make up for the fact that sick people are more likely to sign up for insurance. Insurers also save on administrative expense, since they do not have to screen for policyholders. People who are unemployed or work too few hours to be covered by their employees are now covered by the State Health Insurance Plan (SHIP). Most of

the 18,000 Hawaiians on SHIP are poor, but not poor enough to receive Medicaid. Thanks to the Prepaid Health Care Act, SHIP and Medicaid, only 2% of the population lacks some kind of health coverage, compared to 14% in the continental United States (589).

Hawaii's health care system is far from perfect. The same problems found in the states are beginning to affect Hawaii. Cost of new technology and medical wage inflation along with the failure of Medicare and Medicaid to pay adequately has caused cost shifting that is found so prevalent in the inland states. Last year, Medicaid required a \$64 million emergency appropriation from the state legislature. Next year, the program is projected to run \$34 million short. Medicaid's under-financing has left many patients without medical care because doctors refuse them (589).

Canada's Experience

Thirty years ago Canada enacted a program to bring health care within reach of all its citizens. By 1971, Canada's provincial governments were paying the medical bills for everyone in Canada. As health care cost began to skyrocket in the United States, Canada's system stayed on an even keel while still providing more services to all of Canada. Contrary to what some in the U.S. health-care industry would have you believe, Canada does not have socialized medicine. Medicare, as Canada's health care system is called, is simply a social insurance plan, much like Social Security and Medicare for older people in the U.S. Canada's doctors do not work on salary for the government. Canadians pay

for health care through a variety of federal and provincial taxes, just as Americans pay for Social Security and Medicare through payroll taxes. The government of each province pay the medical bills for its citizens. Because the government is the primary payer of medical bills, Canada's health care system is referred to as a "single payer" arrangement.

Adopting a system such as Canada's brings up the debate on whether Canada's health care plan is truly a viable alternative for the United States to go to. Both positive and negative sides have truly legitimate arguments as to why or why not a plan similar to Canada's should be accepted. Critics against such a plan say their system is on the verge of breaking down and is so inefficient in delivering services that proper care is not being delivered. Proponents of a policy similar to Canada's health plan say this is precisely what the critics against the plan want you to believe. These supporters of the plan believe that information is being highly distorted by influences who would have a lot to lose if a health system is enacted (ex. insurance companies). Some of the criticisms against going to a health plan similar to Canada are: an inefficient system because of long waits for care because lack of hospital beds and waiting lists, a system that uses the United States as a safety valve, a poor system because of lack of technology, overuse and special access for the influential, and costs that are relatively comparable to the United State when everything is taken into account.

Canada's system works much better for Canada than the U.S. health care system works for America. The problem with Canada's

system is that it does not fit America. "Simply picking up the Canadian system and transplanting it to the U.S. system would be infeasible. The Canadians have a completely different government than the U.S. The Prime Minister does not have to deal with the system of checks and balances. The U.S. health care system of government was built on the basic premises of individual rights and limited government. This of course means our form of government is much more susceptible to special interests such as doctors, insurance companies and hospitals" (Block 26).

Summary: Why Managed Competition is the Best

Marcia Angell, Executive Editor of the New England Journal of Medicine, believes that six criteria must be included in a reform of health care for the system to be workable. These six criteria are;

1. The health care system should be coherent--the system of today is incredibly complicated, chaotic and contradicting. There are multiple payers and forms of delivery, each with different rules and incentives, and there is a large administrative bureaucracy devoted to shifting costs. We need a simplified, comprehensive system.
2. The system should be universal--everyone who needs health care should receive health care regardless of ability to pay.
3. The system should be comprehensive--the system should cover long-term care and preventive service.

4. The system should be structured to contain costs--the present system has no way to control inflationary costs. There are no caps on spending and the system is rewarded on expanding the volume(providing more services to more patients more often). Our present system reacts to the effects caused by inflation instead of dealing with the causes.
5. The system should be paid for fairly--the costs should be distributed according to the ability to pay. Business, especially small businesses, should not bare the entire brunt of the costs.
6. The system should foster the morale of doctors and patients--Today doctors are frustrated by the growing regulations that interfere with their ability to provide the best care they can for each patient. Patients in turn feel vulnerable to limited care they get. Each has to sift through tons of paperwork to get or give care.

Dr. Angell sees that not all these criteria can be met all at once. Instead, the reform must come in stages, but the system must be restructured, not just patched (801).

Using Dr. Angell's criteria, the system that best fits is managed competition. The so termed universal coverage plan such as Canada's does not fit the criteria because it does not adhere to criteria number four and six. Although the system is universal, coherent, fairly paid for and comprehensive, the system is very debilitating to patient and doctor morale because of long waiting lists to receive care. The doctor cannot render care that he has

been trained for and this makes both the patient and doctor frustrated. The Canadian system also has begun to face the inflationary costs and under-funding that the U.S. system has now. For America to go to a system that may be close to failing would be a wrong step. Also, as previously mentioned, Canada's system does not fit the psyche of America.

Hawaii's health care plan seems to satisfy the same criteria as Canada's plan, but it also seems to be experiencing the inflationary cost and underfunding that Canada is experiencing. Hawaii's and Canada's systems seem to be heading toward where the U.S. inland states are now, instead of moving away from the U.S. inland states' problems of inflationary costs and underfunding. This fact combined with the fact that Hawaiian's lifestyles and mentality are completely different from the inland states causes their health care plan to be unacceptable to the U.S.

This leads to managed competition. Xerox's and the state of Minnesota's examples of managed competition shows that the system could be used to purge the waste which has caused the system to be incoherent and inflationary. The Xerox Corporation and the state of Minnesota were able to slow the inflationary pressures which caused premiums rises of 20%. Xerox and Minnesota employees premiums now average around 5.5%. Minnesota's buying pool of 120,000 people shows that a large pool can be efficient. Such large pools can decrease all the red tape because there would be only one payer and one form of delivery the doctors could use. The administrative bureaucracy would lessen because cost shifting could no longer be achieved.

Calpers experience with managed competition shows the system could be nearly universal, comprehensive and paid for fairly. Calpers shows that HIPC's can work. These HIPC's combat the problem of HMO's taking virtually all of their business to large employees. HIPC's are formed so individuals and small businesses can get competitive rates. With the use of Medicare and Medicaid to finance the poor and unemployed, HIPC's could be used to cover nearly everyone in the United States with Health Care.

These three example show that the system could be run more efficient if managed competition was implemented in every part of the United States. This efficiency would allow doctors to do what they do best, practice medicine. This would foster the morale of the doctors in turn giving more patients confidence in the abilities of their doctors.

These examples of managed competition that are in place today show that if the system is run efficiently without too much government control, then managed competition can satisfy all six of Dr. Angell's criteria. As Dr. Angell said, the health care reform must come in stages. The problem is that the American psyche wishes to believe in quick fixes that can not happen in a problem as complex as health care.

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